Washington State
**Department of Social
& Health Services**

DIVISION OF DEVELOPMENTAL DISABILITIES
WAIVER CHANGE OF STATUS

CLIENT DATA

CLIENT'S NAME	DDD NUMBER

CASE MANAGER'S NAME (PLEASE PRINT)	REGION	TELEPHONE NUMBER (INCLUDE AREA CODE)

CASE MANAGER'S SIGNATURE	DATE

☐ Basic ☐ Core

☐ Basic Plus ☐ CPP

Date change is effective: _____

☐ DSHS 14-084 sent to CSO. Attach a copy of this form.

☐ CCDB updated ☐ SSPS revised or terminated

TYPE OF CHANGE

☐ **Termination**. Indicate the reason below and terminate SSPS waiver codes.

☐ Death ☐ Financially ineligible ☐ No longer meets waiver eligibility criteria

☐ No longer a resident of WA ☐ Moved into an institution ☐ No longer wants to be on the waiver

☐ Cannot be located ☐ Refuses to abide by established waiver regulations ☐ No longer needs or uses a waiver service

☐ Being enrolled into a different DDD HCBS waiver

☐ Other (specify):

☐ **Regional Transfer**.

From: Region _____ Program Type _____ Program Name _____

To: Region _____ Program Type _____ Program Name _____

☐ **Admission to** ICF/MR, nursing home, hospital, medical setting or other facility that exceeds one full calendar month.

Facility name and type:

Admission date _____ Estimated discharge date _____ Next POC date _____

SSPS codes terminated effective (date) _____

☐ **Name change to**: _____
     LAST   FIRST   MIDDLE INITIAL

☐ **Other change** (please explain):

COPIES TO: HQ Waiver Program Manager; Regional Waiver Coordinator; Client File; CSO (via DSHS 14-084)

DSHS 10-275 (REV. 03/2004)